World Health Organization

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Consolidated guideline on sexual and reproductive health and rights of women living with HIV

Executive summary

An integrated approach to health and human rights lies at the heart of ensuring the dignity and well-being of women living with HIV.

HIV is not only driven by gender inequality, but it also entrenches gender inequality, leaving women more vulnerable to its impact. Providing sexual and reproductive health interventions for women living with HIV that are grounded in principles of gender equality and human rights can have a positive impact on their quality of life; it is also a step towards long-term improved health status and equity.

Introduction

There were an estimated 17.8 million women aged 15 and older living with HIV in 2015, constituting 51% of all adults living with HIV. Adolescent girls and young women are particularly affected; in 2015 they constituted 60% of young people aged 15–24 years who were living with HIV, and they also accounted for 58% of newly acquired HIV infections among young persons in that age group. In many countries, women living with HIV do not have equitable access to good-quality health services and are also faced with multiple and intersecting forms of stigma and discrimination. Furthermore, women living with HIV are disproportionately vulnerable to violence, including violations of their sexual and reproductive rights.

Many significant changes in HIV-related policies, research and practice have occurred in the 10 years since the World Health Organization (WHO) published *Sexual and reproductive health of women living with HIV/AIDS: guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings* in 2006. These changes include the rapid expansion of antiretroviral therapy (ART) and the release in 2015 of WHO recommendations to offer immediate ART to all individuals living with HIV and to offer pre-exposure prophylaxis (PrEP) to individuals at substantial risk of HIV infection as an additional prevention choice. Given the significant difference in scope, this guideline was viewed as a new submission by the WHO Guidelines Review Committee, rather than an update of the 2006 guidelines. This guideline responds to requests from organizations, institutions and individuals for guidance which consolidates existing recommendations specific to women living with HIV along with new recommendations and good practice statements. It is expected to support front-line health-care providers, programme managers and public health policy-makers around the world to better address the sexual and reproductive health and rights (SRHR) of women living with HIV.

The starting point for this guideline is the point at which a woman has learnt that she is living with HIV, and it therefore covers key issues for providing comprehensive SRHR-related services and support for women living with HIV. As women living with HIV face unique challenges and human rights violations related to their sexuality and reproduction within their families and communities, as well as from the health-care institutions where they seek care, particular emphasis is placed on the creation of an enabling environment to support more effective health interventions and better health outcomes.

This guideline is meant to help countries to more effectively and efficiently plan, develop and monitor programmes and services that promote gender equality and human rights and hence are more acceptable and appropriate for women living with HIV, taking into account the national and local epidemiological context. It discusses implementation issues that health interventions and service delivery must address to achieve gender equality and support human rights.

This guideline aims to provide:

- **Evidence-based recommendations** for the SRHR of women living with HIV in all of their diversity, with a particular focus on settings where the health system has limited capacity and resources; and

- **Good practice statements** on key operational and service delivery issues that need to be addressed to (i) increase access to, uptake of, and the quality of outcomes of sexual reproductive health (SRH) services, (ii) improve human rights and (iii) promote gender equality for women living with HIV.

A woman-centred approach

Woman-centred health services involve an approach to health care that consciously adopts the perspectives of women, their families and communities. This means that health services see women as active participants in, as well as beneficiaries of, trusted health systems that respond to women's needs, rights and preferences in humane and holistic ways. Care is provided in ways that respect women's autonomy in decision-making about their health, and services must include provision of information and options to enable women to make informed choices. The needs and perspectives of women, their families and communities are central to provision of care, and to the design and implementation of programmes and services. A woman-centred approach is underpinned by two guiding principles: promotion of human rights and gender equality.

Guiding principles

Human rights: An integrated approach to health and human rights lies at the heart of ensuring the dignity and well-being of women living with HIV. This includes, but is not limited to, the right to the highest attainable standard of health; the right to life and physical integrity, including freedom from violence; the right to equality and non-discrimination on the basis of sex; and the right to freedom from torture or cruel, inhuman or degrading treatment. The right to SRH is an integral part of the right to health, enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights.

Gender equality: The promotion of gender equality is central to the achievement of SRHR of all women, including women living with HIV in all their diversity. This means recognizing and taking into account how unequal power in women's intimate relationships, harmful gender norms and women's lack of access to and control over resources affect their access to and experiences with health services.

Guideline development methods

The WHO Department of Reproductive Health and Research (RHR) led the development of this consolidated guideline, following WHO procedures and reporting standards laid out in the 2014 *WHO handbook for guideline development*. To help ensure that the guidance appropriately reflects the concerns of women living with HIV in all their diversity, WHO commissioned a global survey on the SRHR priorities of women living with HIV – the Global Values and Preferences Survey (GVPS)[1]. This process was placed at the heart of the development of this guideline and the findings of the survey are included throughout the guideline.

To develop the scope of this guideline, the WHO Guideline Steering Group (SG) mapped all existing WHO SRHR guidance for women living with HIV, then reviewed these documents to determine the relevance of existing recommendations that have undergone the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) for inclusion in this consolidated guideline. The SG identified the following eight topic areas for new

1. Orza L, Welbourn A, Bewley S, Crone ET, Vazquez M; Salamander Trust. Building a safe house on firm ground: key findings from a global values and preferences survey regarding the sexual and reproductive health and human rights of women living with HIV. Geneva: World Health Organization; 2014 (http://salamandertrust.net/wp-content/uploads/2016/09/BuildingASafeHouseOnFirmGroundFINALreport190115.pdf).

recommendations or good practice statements: psychosocial support, ageing and healthy sexuality, economic empowerment and resource access (including food security), integration of SRHR and HIV services, empowerment and self-efficacy around safer sex and reproductive decision-making, facilitating safe disclosure for women living with HIV who fear or experience violence, modes of delivery for best maternal and perinatal outcomes (specifically caesarean section), and safe medical and surgical abortion. Development of the new recommendations and good practice statements to respond to these eight topic areas began with systematic and narrative reviews of the evidence. The Guideline Development Group (GDG) assessed the quality of the available evidence for the new recommendations and considered the benefits and risks, values and preferences, human rights, equity, costs and feasibility of implementation to determine the strength of each recommendation.

Creating an enabling environment

Implementing comprehensive and integrated SRHR and HIV programmes to meet the health needs and rights of the diverse group of women living with HIV requires that interventions be put into place to overcome barriers to service uptake, use and continued engagement. In all epidemic contexts, these barriers occur at the individual, interpersonal, community and societal levels. They may include challenges such as social exclusion and marginalization, criminalization, stigma, gender-based violence and gender inequality, among others. Strategies are needed across health system building blocks to improve the accessibility, acceptability, affordability, uptake, equitable coverage, quality, effectiveness and efficiency of services for women living with HIV. If left unaddressed, such barriers undermine health interventions and the SRHR of women living with HIV.

Implementation and updating of the guideline

Action on the recommendations in this guideline requires a strategy that is informed by evidence, appropriate to the local context, and responsive to the needs and rights of women living with HIV. In addition, programmes should aim to achieve equitable health outcomes, promote gender equality, and deliver the highest-quality care efficiently at all times. Effective implementation of the recommendations and good practice statements in this guideline will likely require reorganization of care and redistribution of health-care resources, particularly in low- and middle-income countries. Potential barriers are noted and a phased approach to adoption, adaptation and implementation of the guideline recommendations is advised.

During the guideline development process, the GDG identified important knowledge gaps that need to be addressed through primary research. This guideline will be updated five years after publication unless significant new evidence emerges that necessitates earlier revision.

Tables 1 and 2 present the new and existing recommendations and good practice statements, respectively. Figure 1 presents a visual framework that brings together all the elements of the guideline, with women living with HIV (and their expressed values and preferences) at the core.

Table 1: Summary list of WHO recommendations for the sexual and reproductive health and rights (SRHR) of women living with HIV

Note: Where recommendations apply to "key populations" this includes women living with HIV and therefore these have been included in these guidelines.

A. Creating an enabling environment	
Recommendation (REC)	**Strength of recommendation, quality of evidence**
Healthy sexuality across the life course	
REC A.1: Adolescent-friendly health services should be implemented in HIV services to ensure engagement and improved outcomes.[1]	Strong recommendation, low-quality evidence
Integration of SRHR and HIV services	
REC A.2: In generalized epidemic settings, antiretroviral therapy (ART) should be initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings, with linkage and referral to ongoing HIV care and ART, where appropriate.	Strong recommendation, very low-quality evidence
REC A.3: Sexually transmitted infection (STI) and family planning services can be integrated within HIV care settings.	Conditional recommendation, very low-quality evidence
REC A.4, A.5 and A.6: Decentralization of HIV treatment and care should be considered as a way to increase access to and improve retention in care:	
– initiation of ART in hospitals with maintenance of ART in health facilities;	Strong recommendation, low-quality evidence
– initiation and maintenance of ART in peripheral health facilities;	Strong recommendation, low-quality evidence
– initiation of ART at peripheral health facilities with maintenance at the community level.	Strong recommendation, moderate-quality evidence
REC A.7: Trained and supervised lay providers can distribute ART to adults, adolescents and children living with HIV.	Strong recommendation, low-quality evidence
REC A.8: Trained non-physician clinicians, midwives and nurses can initiate first-line ART.	Strong recommendation, moderate-quality evidence
REC A.9: Trained non-physician clinicians, midwives and nurses can maintain ART.	Strong recommendation, moderate-quality evidence
REC A.10: Trained and supervised community health workers can dispense ART between regular clinical visits.	Strong recommendation, moderate-quality evidence
Protection from violence and creating safety	
REC A.11: Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. Health-care providers should, as a minimum, offer first-line support when women disclose violence. If health-care providers are unable to provide first line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.[2]	Strong recommendation, indirect evidence
REC A.12: Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care.	Strong recommendation, indirect evidence

1. Reference for this and all the existing recommendations in the next section on integration of services: Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf).
2. Reference for this and all the rest of the existing recommendations in this section on violence and safety: Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf).

REC A.13: In-service training and training at pre-qualification level and in first-line support for women who have experienced intimate partner violence and sexual assault should be provided to health-care providers (in particular doctors, nurses and midwives).	Strong recommendation, very low-quality evidence
REC A.14: Pregnant women who disclose intimate partner violence should be offered brief to medium-duration empowerment counselling (up to 12 sessions) and advocacy/support, including a safety component, offered by trained service providers where health-care systems can support this. The extent to which this may apply to settings outside of antenatal care, or its feasibility in low- or middle-income countries, is uncertain.	Conditional recommendation, low-quality evidence
REC A.15: Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.	Strong recommendation, very low-quality evidence
REC A.16: Mandatory reporting of intimate partner violence to the police by the health-care provider is not recommended. However, health-care providers should offer to report the incident to the appropriate authorities (including the police) if the woman wants this and is aware of her rights.	Strong recommendation, very low-quality evidence

Community empowerment

REC A.17: Provide free HIV and tuberculosis (TB) treatment for health workers in need facilitating the delivery of these services in a non-stigmatizing, gender-sensitive, confidential, and convenient setting when there is no staff clinic and/or their own facility does not offer ART, or where health workers prefer services off-site.[3]	Strong recommendation, weak evidence
REC A.18: Introduce new, or reinforce existing, policies that prevent discrimination against health workers with HIV or TB, and adopt interventions aimed at stigma reduction among colleagues and supervisors.[4]	Strong recommendation, moderate-quality evidence

B. Health interventions

Recommendation (REC)	Strength of recommendation, quality of evidence
Sexual health counselling and support	
REC B.1 (NEW): WHO recommends that for women living with HIV, interventions on self-efficacy and empowerment around sexual and reproductive health and rights should be provided to maximize their health and fulfil their rights.	Strong recommendation, low-quality evidence
REC B.2: Brief sexuality-related communication (BSC) is recommended for the prevention of sexually transmitted infections among adults and adolescents in primary health services.[5]	Strong recommendation, low- to moderate-quality evidence
REC B.3: Training of health-care providers in sexual health knowledge and in the skills of BSC is recommended.[6]	Strong recommendation, low- to very low-quality evidence

3. Joint WHO/ILO policy guidelines on improving health worker access to prevention, treatment and care services for HIV and TB. Geneva: World Health Organization; 2010 (http://apps.who.int/iris/bitstream/10665/44467/1/9789241500692_eng.pdf).
4. Ibid.
5. Brief sexuality-related communication: recommendations for a public health approach. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/170251/1/9789241549004_eng.pdf).
6. Ibid.

Violence against women services	
REC B.4 (NEW): WHO recommends that policy-makers and service providers who support women living with HIV who are considering voluntary HIV disclosure should recognize that many fear, or are experiencing, or are at risk of intimate partner violence.	Strong recommendation, low-quality evidence
REC B.5 (NEW): WHO recommends that interventions and services supporting women living with HIV who are considering voluntary HIV disclosure should include discussions about the challenges of their current situation, the potential associated risk of violence, and actions to disclose more safely, and facilitate links to available violence prevention and care services.	Strong recommendation, low-quality evidence
REC B.6: Adolescents should be counselled about the potential benefits and risks of disclosure of their HIV status to others and empowered and supported to determine if, when, how and to whom to disclose.[7]	Conditional recommendation, very low-quality evidence
REC B.7: HIV testing services for couples and partners, with support for mutual disclosure, should be offered to individuals with known HIV status and their partners.[8]	Strong recommendation, low-quality evidence for all people with HIV in all epidemic settings; conditional recommendation, low-quality evidence for HIV-negative people depending on the country-specific HIV prevalence
REC B.8: Initiatives should be put in place to enforce privacy protection and institute policy, laws and norms that prevent discrimination and promote tolerance and acceptance of people living with HIV. This can help create environments where disclosure of HIV status is easier.[9]	Strong recommendation, low-quality evidence
REC B.9: Children of school age* should be told their HIV positive status; younger children should be told their status incrementally to accommodate their cognitive skills and emotional maturity, in preparation for full disclosure.[10]	Strong recommendation, low-quality evidence
REC B.10: Children of school age* should be told the HIV status of their parents or caregivers; younger children should be told this incrementally to accommodate their cognitive skills and emotional maturity.[11]	Conditional recommendation, low-quality evidence
* In the document, school-age children are defined as those with the cognitive skills and emotional maturity of a normally developing child of 6–12 years.	

7. HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf).
8. Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: recommendations for a public health approach. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972_eng.pdf).
9. Guideline on HIV disclosure counselling for children up to 12 years of age. Geneva: World Health Organization; 2011 (http://apps.who.int/iris/bitstream/10665/44777/1/9789241502863_eng.pdf).
10. Ibid.
11. Ibid.

Family planning and infertility services	
REC B.11: In countries where HIV transmission occurs among serodiscordant couples, where discordant couples can be identified and where additional HIV prevention choices for them are needed, daily oral PrEP (specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner.[12]	Conditional recommendation, high-quality evidence
REC B.12: ART should be initiated in all adults living with HIV, regardless of WHO clinical stage and at any CD4 cell count.[13]	Strong recommendation, moderate-quality evidence
REC B.13: The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections (STIs).[14]	Strong recommendation, moderate-quality evidence
REC B.14: Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can use the following hormonal contraceptive methods without restriction: combined oral contraceptive pills (COCs), combined injectable contraceptives (CICs), contraceptive patches and rings, progestogen-only pills (POPs), progestogen-only injectables (POIs; depot medroxyprogesterone acetate [DMPA] and norethisterone enanthate [NET-EN]), and levonorgestrel (LNG) and etonogestrel (ETG) implants (MEC Category 1). Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can generally use the LNG-IUD (MEC Category 2) (Part I, section 12b).[15]	Strength of recommendation is indicated by MEC category, which is noted in text.[16] Moderate- to very low-quality evidence
REC B.15: Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) can use the following hormonal contraceptive methods without restriction: COCs, CICs, contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) should generally not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease (WHO stage 1 or 2). However, women who already have an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation). LNG-IUD users with severe or advanced HIV clinical disease should be closely monitored for pelvic infection (Part I, section 12c).	Moderate- to very low-quality evidence
REC B.16: Women taking any nucleoside/nucleotide reverse transcriptase inhibitor (NRTI) can use all hormonal contraceptive methods without restriction: COCs, contraceptive patches and rings, CICs, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1) (Part I, section 12d).	Low- to very low-quality evidence
REC B.17: Women using ART containing either efavirenz or nevirapine can generally use COCs, patches, rings, CICs, POPs, NET-EN and implants (MEC Category 2). However, women using efavirenz or nevirapine can use DMPA without restriction (MEC Category 1) (Part I, section 12d).	Low- to very low-quality evidence

12. Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV: recommendations for use in the context of demonstration projects. Geneva: World Health Organization; 2012 (http://www.who.int/hiv/pub/guidance_prep/en/).
13. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf).
14. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf).
15. Reference for this and all the rest of the existing recommendations in this section on contraception, and for the next footnote: Medical eligibility criteria for contraceptive use, fifth edition. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf).
16. MEC categories (Medical eligibility criteria for contraceptive use, fifth edition, WHO, 2015):
    1: A condition for which there is no restriction for the use of the contraceptive method
    2: A condition where the advantages of using the method generally outweigh the theoretical or proven risks
    3: A condition where the theoretical or proven risks usually outweigh the advantages of using the method
    4: A condition which represents an unacceptable health risk if the contraceptive method is used.

REC B.18: Women using the newer non-nucleoside/nucleotide reverse transcriptase inhibitors (NNRTIs), etravirine and rilpivirine, can use all hormonal contraceptive methods without restriction (MEC Category 1) (Part I, section 12d).	Low- to very low-quality evidence
REC B.19: Women using protease inhibitors (e.g. ritonavir and antiretrovirals [ARVs] boosted with ritonavir) can generally use COCs, contraceptive patches and rings, CICs, POPs, NET-EN, and LNG and ETG implants (MEC Category 2), and can use DMPA without restriction (MEC Category 1) (Part I, section 12d).	Low- to very low-quality evidence
REC B.20: Women using the integrase inhibitor raltegravir can use all hormonal contraceptive methods without restriction (MEC Category 1) (Part I, section 12d).	Low- to very low-quality evidence
REC B.21: Intrauterine device (IUD): Women using ARV medication can generally use LNG-IUDs (MEC Category 2), provided that their HIV clinical disease is asymptomatic or mild (WHO stage 1 or 2). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) should generally not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease. However, women who already have an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation). LNG-IUD users with severe or advanced HIV clinical disease should be closely monitored for pelvic infection (Part I, section 12d).	Low- to very low-quality evidence
Antenatal care and maternal health services	
REC B.22 (NEW): WHO recommends that elective caesarean section (C-section) should not be routinely recommended to women living with HIV.	Strong recommendation, low-quality evidence
REC B.23: Late cord clamping (performed approximately 1–3 minutes after birth) is recommended for all births while initiating simultaneous essential newborn care.[17]	Strong recommendation, moderate-quality evidence
REC B.24: ART should be initiated in all adolescents living with HIV, regardless of WHO clinical stage and at any CD4 cell count.[18]	Conditional recommendation, low-quality evidence
REC B.25: As a priority, ART should be initiated in all adolescents with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adolescents with a CD4 count ≤ 350 cells/mm^3.[19]	Strong recommendation, moderate-quality evidence
REC B.26: ART should be initiated in all pregnant and breastfeeding women living with HIV, regardless of WHO clinical stage and at any CD4 cell count, and continued lifelong.[20]	Strong recommendation, moderate-quality evidence